BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against:	)	
HARRY LIFSCHUTZ, M.D.	)	**Case No. 800-2014-004065**
Physician's and Surgeon's Certificate No. G42802	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 29, 2019.

IT IS SO ORDERED: July 30, 2019.

MEDICAL BOARD OF CALIFORNIA

David Warmoth, Vice-Chair
Panel A

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against: **HARRY LIFSCHUTZ, M.D.** **81812 Doctor Carreon Blvd., Ste. C** **Indio , CA 92201** **Physician's and Surgeon's Certificate No. G42802** Respondent.	Case No. 800-2014-004065 OAH No. 2017060725 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

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2. Respondent Harry Lifschutz, M.D. (Respondent) is represented in this proceeding by John D. Harwell, Esq., whose address is 225 27th Street, Manhattan Beach, CA 90266

3. On or about July 25, 1980, the Board issued Physician's and Surgeon's Certificate No. G42802 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-004065, and will expire on August 31, 2017, unless renewed.

JURISDICTION

4. On March 15, 2017, Accusation No. 800-2014-004065 was filed before the Board. A true and correct copy of Accusation No. 800-2014-004065 and all other statutorily required documents were properly served on Respondent on March 15, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. On January 4, 2019, Third Amended Accusation No. 800-2014-004065 was filed before the Board and is currently pending against Respondent. A true and correct copy of Third Amended Accusation No. 800-2014-004065, along with a true and correct copy of a Supplemental Statement to Respondent were properly served on Respondent on January 4, 2019. A true and correct copy of Third Amended Accusation No. 800-2014-004065 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Third Amended Accusation No. 800-2014-004065. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Third Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision;

and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Third Amended Accusation No. 800-2014-004065, if proven at hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. G42802.

10. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition for revocation of probation is filed against him before the Board, all of the charges and allegations contained in Third Amended Accusation No. 800-2014-004065 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. G42802 is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G42802 issued to Respondent Harry Lifschutz, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. **EDUCATION COURSE.** Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 20 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

2. **CLINICAL COMPETENCE ASSESSMENT PROGRAM.** Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence

assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

3. **MONITORING - PRACTICE.** Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3)

calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

4. **PROHIBITED PRACTICE.** During probation, Respondent is prohibited from performing any vascular procedures under anesthesia or conscious sedation. After the effective date of this Decision, all patients being treated by Respondent shall be notified that the Respondent is prohibited from performing any vascular procedures under anesthesia or conscious sedation. Any new patients must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

5. **NOTIFICATION.** Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Third Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. **OBEY ALL LAWS.** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. **QUARTERLY DECLARATIONS.** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. **GENERAL PROBATION REQUIREMENTS.**

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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9. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE.** Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. **NON-PRACTICE WHILE ON PROBATION.** Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or

Controlled Substances; and Biological Fluid Testing.

11. **COMPLETION OF PROBATION.** Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. **VIOLATION OF PROBATION.** Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. **LICENSE SURRENDER.** Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. **PROBATION MONITORING COSTS.** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, John D. Harwell, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6/10/19

HARRY LIFSCHUTZ, M.D.
Respondent

I have read and fully discussed with Respondent Harry Lifschutz, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6/10/19

JOHN D. HARWELL, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: June 11, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Third Amended Accusation No. 800-2014-004065

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Third Amended Accusation Against: **Harry Lifschutz, M.D.** **81812 DOCTOR CARREON BLVD., STE. C** **INDIO, CA 92201** **Physician's and Surgeon's Certificate No. G42802,** **Respondent.**	Case No. 800-2014-004065 **THIRD AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Third Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 25, 1980, the Medical Board issued Physician's and Surgeon's Certificate No. G42802 to Harry Lifschutz, M.D. (Respondent). Physician's and Surgeon's Certificate No. G42802 was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2019, unless renewed.

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JURISDICTION

3. This Third Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or other such action taken in relation to discipline by the Board.

5. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter. [Chapter 5, the Medical Practices Act.]

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. G42802 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of patients L.D., B., C.L., and P.S.A., as more particularly alleged hereinafter:

PATIENT L.D.:

8. On or about February 2, 2015, patient L.D., a 70 year old female with end-stage renal disease, presented with hyperkalemia.[1] Patient L.D. had a right upper extremity arteriovenous graft[2] that was occluded and a left femoral vein dialysis catheter that had malfunctioned.

(a) On or about February 4, 2015, Respondent performed a thrombectomy[3] and revision of a right arm graft[4] on patient L.D. However, while Respondent described the procedure as a thrombectomy and revision in the brief operative report, stating "procedure performed," in the description of the procedure, no revision is described.

(b) On or about February 5, 2015, patient L.D.'s graft was patent (open or exposed). However, Respondent decided not to use the exposed access and, instead, placed a tunneled

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[1] Hyperkalemia describes a potassium level in blood that is higher than normal.

[2] An arteriovenous graft is an artificial tube inserted by a surgeon underneath the skin of the forearm, upper arm or thigh. One end of the tube connects to an artery, and the other end connects to a vein in the same limb.

[3] A thrombectomy is a surgical procedure used to remove a blood clot (thrombus) from a vessel.

[4] When graft failure occurs, revision procedure repairs the graft.

catheter[5] in patient L.D. Right internal jugular vein placement was attempted, and during the attempt, patient L.D. suffered cardiopulmonary arrest. Cardiopulmonary Resuscitation (CPR) was performed. A right tube thoracostomy[6] was placed that drained 600 cc of blood. Patient L.D. subsequently passed away.

PATIENT B:

9. On or about January 14, 2013, Patient B was admitted with a thrombosed right lower extremity bypass. Patient B had a history of multiple lower extremity revascularizations, including a femoral popliteal artery bypass, which Respondent incorrectly described as a bilateral femoral infrapopliteal artery bypass. Patient B also had a history of stage IIIB bronchogenic lung cancer. Patient B presented to Respondent with acute right lower extremity ischemia.

(a) On or about January 15, 2013, Patient B was placed on heparin and underwent an arteriogram.[7] However, the distal vessels could not be well visualized.

(b) On or about January 16, 2013, Patient B was taken to surgery for an open revascularization[8] and a graft blood clot removal (thrombectomy) was performed. The distal tibial artery, the artery of the leg carries blood to the leg foot, could not be opened. A patch angioplasty closure was made. After the thrombectomy and patch angioplasty, Respondent failed to obtain a post-procedure arteriogram or other imaging that would have shown whether thrombosis was due to a problem outside of the surgical field.

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[5] A tunneled catheter is a tunneled central line a thin tube placed in a vein for long-term use. The catheter is tunneled under the skin

[6] Tube thoracostomy is the insertion of a tube into the pleural cavity to drain air, blood, or other fluids.

[7] An arteriogram is an x-ray of arteries.

[8] Revascularization is the restoration of perfusion (fluid through the circulatory system) to a body part or organ that has suffered ischemia (inadequate blood supply.)

(c) On or about January 17, 2013, a computed tomography angiography demonstrated that the bypass was open, with a high grade of narrowing and bleeding at the distal connection. No open revision and repair of the bleeding anastomosis[9] was performed and no patient examination and discussion of the alternatives, and/or risks and benefits of various actions, and/or Patient B's agreement was documented. Patient B had a repeat arteriogram, a covered stent was placed to control bleeding, and Respondent performed a thrombolysis.

(d) On or about January 18, 2013, a computed tomography angiography demonstrated that Patient B's bypass graft was occluded. Patient B had an open, but diseased right anterior tibial artery.

(e) On or about January 19, 2013, Patient B underwent a right above-the-knee amputation.

Patient C.L.:

10. In or about September of 2012, patient C.L., a 66-year-old male patient presented to Respondent with end stage renal disease, secondary to hypertension, and was seen by Respondent for urinary retention. Respondent placed a suprapubic catheter at that time.

(a) On or about December 5, 2013, patient C.L. was hospitalized for weakness, metabolic acidosis and respiratory problems.

(b) On or about December 7, 2013, Respondent consulted on patient C.L. for dialysis access and placed a right femoral catheter.

(c) On or about December 9, 2013, Respondent performed a left upper extremity arteriovenous fistula[10] and placed a left internal jugular tunneled catheter.

(d) On or about January 14, 2014, patient C.L. was hospitalized.

(e) On or about January 17, 2014, Respondent was asked to see patient C.L., but Respondent did not see him until January 19, 2014. Respondent failed to document that consultation in patient C.L.'s medical records.

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[9] Anastomosis is a surgically created connection between adjacent structures, such as blood vessels.

[10] A fistula is a surgically-made passageway between two portions of a person's anatomy.

(f) On or about January 20, 2014, Respondent created a right upper extremity arteriovenous fistula.

(g) On or about January 28, 2014, Respondent saw patient C.L., and his arteriovenous fistula was patent at that time.

(h) On or about February 10, 2014, patient C.L. was readmitted with sepsis and a prior culture of the catheter exit site that demonstrated methicillin resistant staphylococcus aureus (MRSA).

(i) On or about February 14, 2014, Respondent replaced patient C.L.'s left internal jugular tunneled catheter. Respondent performed no examination or assessment of patient C.L.'s right arteriovenous fistula performed during his admission.

(j) On or about March 20, 2014, Respondent saw patient C.L. for an office visit. No physical examination was performed. Respondent assessed a need for a revision of the right arm AV fistula on an urgent basis. However, Respondent did not document whether the fistula was thrombosed or non-matured,[11] and did not document the date of the revision. However, a surgery scheduling questionnaire indicates that the surgery was scheduled for March 27, 2014.

(k) On or about March 30, 2014, patient C.L. presented with catheter sepsis. Respondent removed the left internal jugular catheter and sent the tip for culture. He placed a right femoral dialysis catheter at that time. Patient C.L.'s white blood cell count was 30,000, and he was in septic shock. Patient C.L.'s condition worsened and he died on April 6, 2014.

Patient P.S.A.:

11. On or about February 29, 2012, Respondent saw patient P.S.A., a 27-year-old male patient, who was admitted with a one-day history of right lower quadrant pain, nausea, and anorexia, with marked tenderness in the lower right quadrant. A MRI revealed a dilated appendix with periappendiceal fluid suggestive of acute appendicitis.

(a) On or about February 29, 2012, at approximately 12:08 p.m., Respondent performed an attempted laparoscopic appendectomy on patient P.S.A. Patient P.S.A.'s appendix could not be

[11] Non-mature fistula: an autologous arteriovenous fistula needs time to mature and for the vein to enlarge to a size where it can be needled.

identified. The procedure was converted to an open procedure. A right lower quadrant incision was performed. The base of the cecum[12] was described as "destroyed." The cecum was over-sewn and repaired with Monocryl sutures.[13] Surgery ended at approximately 12:35 p.m.

(b) Respondent's pathological examination of patient P.S.A. did not identify an appendix.

(c) Postoperatively, patient P.S.A. had severe leukocytosis.[14] He developed increasing shortness of breath and abdominal distention. A computed tomography (CT) scan taken on March 5, 2012, demonstrated fluid collections but no definite abscess. Patient P.S.A. was transferred to the Intensive Care Unit (ICU) where he eventually required intubation. He was diagnosed with adult Respiratory Distress Syndrome (ARDS). A subsequent CT scan again demonstrated multiple fluid collections without obvious abscess, and did not identify an appendix.

(d) The repair of the cecum led to a leak, which subsequently led to sepsis and multi-organ failure. Patient P.S.A.'s physical symptoms of inflammation of the cecum[15] indicated that Respondent should have performed an ileocecectomy[16] for advanced appendicitis.

12. Respondent committed acts of gross negligence in his care and treatment of patients L.D., B., C.L., and P.S.A. which included, but was not limited to, the following:

(a) For patient L.D.: On or about February 5, 2015, patient L.D.'s graft was patent (open or exposed), however, Respondent placed a central venous catheter in patient L.D.;

(b) For Patient B: On or about January 17, 2013, after Patient B had suffered postoperative bleeding, Respondent attempted thrombosis in the immediate post-operative period, but inadequately documented Patient B's medical records, including

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[12] The cecum is the first part of the large intestine, which forms a dilated pouch.

[13] A Monocryl suture is a synthetic, absorbable suture.

[14] Leukocytosis is a condition in which bone marrow produces too many white blood cells, which may be due to infection or inflammation.

[15] Crohn's disease is characterized by physical symptoms of inflammation of the gastrointestinal tract.

[16] Ileocecectomy: Ileocecal resection is the surgical removal of the cecum along with the most distal portion of the small bowel—specifically, the terminal ileum.

failures to document: the patient's examination; and/or a discussion of alternatives with patient; and/or a discussion of risks and benefits of various action with patient; and/or the patient's agreement.

(c) For patient C.L.: On or about February 14, 2014, Respondent created an inadequate operative report for the catheter replacement, by failing to document whether the patient's catheter was tunneled to a different exit site; and/or; failing to adequately document how the patient was managed; and/or failing to document whether the patient's catheter was tunneled through an area of infection;

(d) For patient C.L.: Respondent failed to adequately document the office notes in the patient's medical records; and

(e) For patient P.S.A.: On or about February 29, 2012, Respondent attempted a primary repair of patient P.S.A.'s "destroyed" cecum, instead of performing a ileocecectomy.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

13. Respondent has further subjected his Physician's and Surgeon's Certificate No. G42802 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients L.D., W.P., C.L., A, P.S.A., B, and C, as more particularly alleged hereinafter:

14. Paragraphs 7 through 12, above, are incorporated by reference and realleged, as if fully set forth herein.

PATIENT W.P.:

15. On or about March 23, 2015, patient W.P. was a 74-year-old male with right knee pain, a history of right knee replacement and gout. An evaluation by an orthopedic surgeon resulted in a finding that the pain was vascular in origin. Respondent saw patient W.P. and concluded that he had significant peripheral arterial disease. Respondent documented only pain, and failed to document the following indications for surgery, which would include but not be

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limited to a description of lower extremity ischemia, pallor, coolness, paresthesia (numbness), paresis,[17] and/or ischemic chest pain.

(a) On or about March 23, 2015, Respondent performed a right femoral to popliteal artery bypass[18] with six millimeters of Polytetrafluoroethylene (PTFE)[19].

(b) Postoperatively, patient W.P.'s symptoms remained unresolved. He subsequently transferred to another facility and, on or about March 31, 2015 underwent epidural injections that improved his condition. Patient W.P. underwent a subsequent MRI that demonstrated muscle tears in the popliteal fossa, a condition that can cause calf tenderness.

PATIENT A:

16. On or about January 25, 2013, Patient A presented to Respondent with a history of peripheral arterial disease, diabetes, obesity, carotid surgery, and coronary artery bypass and right lower extremity bypass using ePTFE. The graft became infected, and had to be removed to control the infection; no revascularization was performed at that time. Patient A was treated with antibiotics, and experienced chest pain after the graft was removed.

(a) On or about January 25, 2013, Patient A was admitted to undergo a right iliac to popliteal artery bypass with a reported seven millimeter autograft, however no autogenous vein was harvested. Respondent did not document an inability to harvest an autogenous vein. In fact, the graft utilized in Patient A's bypass was a biological graft (artegraft) made from bovine carotid artery. Subsequently, when Patient A was prescribed antibiotics in a dosage calculated to prevent infection,[20] Patient A's records incorrectly described the type of graft used.

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[17] Paresis is a condition typified by a weakness of voluntary movement, or partial loss of voluntary movement or by impaired movement.

[18] Femoral popliteal bypass surgery is performed to bypass the blocked portion of main artery in the leg using a piece of another blood vessel.

[19] PTFE/ePTFE: types of synthetic polymer used in vascular grafts to bypass obstructed blood vessels, and in grafts used for dialysis access.

[20] The incidence of infection with an autograft (as incorrectly reported in patient A's medical records) is lower than incident of infection with an artegraft (the graft actually used).

PATIENT C:

17. On or about February 26, 2015, patient C, a then 33-year-old female presented to the JFK Memorial Hospital (JFK) Emergency Department for abdominal pain and vomiting. Patient C was subsequently admitted to JFK for cholelithiasis (gallstones) and acute cholecystitis (inflammation of the gallbladder) and scheduled for an emergent laparoscopic cholecystectomy (surgery to remove gallbladder) to be performed by Respondent the next day.

(a) On or about February 27, 2015, Respondent performed the laparoscopic cholecystectomy with a documented start time of 1:05 p.m. and a stop time of 1:30 p.m. According to Respondent's operative record, "...the gallbladder was decompressed [and] retracted superiorly" with the "cystic duct identified, traced to the gallbladder, doubly hemoclipped and transected..." Respondent documented that the "patient tolerated the procedure well" with no complications listed.

(b) On or about March 1, 2015, at 12:30 p.m., patient C was discharged from the hospital with instructions which included, but were not limited to, following up with respondent at his office in approximately one week.

(c) On or about March 3, 2015, at 4:20 p.m., patient C presented to the Eisenhower Medical Center (EMC) Emergency Department with diffuse intermittent abdominal pain documented as 8 out of 10. A CT scan was conducted which indicated a "moderate amount of free pelvic fluid which is greater than expected in [a] recent postoperative patient" and "mild amount of free fluid and stranding in the gallbladder fossa." The patient was admitted to EMC for further evaluation.

(d) On or about March 5, 2015, a nuclear medicine hepatobiliary scan (HIDA) was conducted with findings that were "worrisome for a biliary lead given history of recent cholecystectomy" with a notation that "delayed images could not be obtained as the patient left AMA [against medical advice]." Before the AMA discharge, it was recommended that patient C have a full and complete HIDA study.[21]

[21] A hepatobiliary (HIDA) scan is an imaging procedure used to diagnose problems of the liver, gallbladder and bile ducts.

(e) On or about March 7, 2015, patient C was seen by respondent after she presented to the JFK Emergency Department with persistent abdominal pain. A CT was performed and the impression was noted as "[s]tatus post cholecystectomy[;] [f]luid throughout the abdomen [;] [and] [i]n the setting of recent cholecystectomy, biliary leak would be a consideration." A "[h]epatobiliary [HIDA] scan [was] suggested for further evaluation" and "surgical admission [was] requested." A HIDA scan was conducted and the impression included, among other things, (1) "[f]indings consistent with a bile leak [and] [l]arge biloma [collection of bile in the abdominal cavity]" and (2) "... [f]indings suggestive of a partial obstruction between the common bile duct and duodenum or may be due to a compression on the common bile duct and/or duodenum by large adjacent biloma" with a notation that "ERCP may be of value for further evaluation." According to Respondent's medical record for the visit, patient C was "admitted with postoperative bile leak" and "now returns with obvious bile leak." Respondent's physical examination at the time included an examination of the abdomen which was noted as "protuberant [unusual or prominent convexity of the abdomen] with marked subxiphoid [near or below the lower part of the sternum] fullness; staples in place [from Respondent's prior surgery]." As part of his evaluation, Respondent reviewed the HIDA scan which he documented as suggesting "a low grade cystic duct leak." Respondent's assessment was "postoperative bile leak, uncomplicated" and his plan included, among other things, "[r]ecommend admission, IV antibiotics; [and] transfer for ERCP [endoscopic retrograde cholangio-pancreatography] evaluation."[22]

(f) On or about March 9, 2015, patient C was discharged from JFK and transferred to Desert Regional Medical Center (DRMC) "since ERCP was not available at this facility."

(g) On or about March 9, 2015, patient C was admitted to DRMC for "[a]bdominal pain for a few days' duration" and for an ERCP to be ordered. The ERCP was performed by Dr. H.A. who documented, in pertinent part:

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[22] ERCP is an endoscopic diagnostic procedure that can be used to confirm, among other things, post-operative bile leaks.

"PROCEDURE IN DETAIL: ... Ampulla was identified. Common bile duct was easily cannulated. Cholangiogram revealed no contrast filling beyond the proximal common bile duct. There appeared to be clips at the proximal common bile duct. Also, I was not able to pass the wire above that area. This is consistent with common bile duct injury. Procedure was therefore terminated."

After the ERCP, Dr. H.A. had a surgical consult with Dr. P.M., who agreed to do an exploratory laparotomy on patient C.

(h). On or about March 12, 2015, Dr. P.M. performed an exploratory laparotomy on patient C. After entering the abdominal cavity, Dr. P.M. irrigated out approximately 3.5 to 4 liters of bile, was then "able to gain access into the area of the triangle of Calot" where he "could identify 2 areas that were leaking bile" and, upon further evaluation, "was able to identify 2 Hemoclips that were across the distal common bile duct..." After being unable to do a T-tube in the area, Dr. P.M., ligated the distal duct, placed a feeding tube and JP drain, and "the operation was directed towards the closure" with Dr. P.M. scheduled to "speak with the patient and her husband about our findings and what our next course of action would be" following the exploratory laparotomy. Biliary stenting was placed in patient C on or about March 16, 2015.

(i) On or about March 17, 2015, patient was discharged from DRMC to home with follow up to take place with a gastroenterologist.

(j) Patient C subsequently had a Rous-en-Y hepaticojejunostomy (bilary reconstruction) surgery at the University of Irvine Medical Center in June 2015.

18. Respondent committed repeated acts of negligence in his care and treatment of patients L.D., W.P., C.L., A, B, P.S.A., and C as follows:

(a) For patient L.D.: On or about February 5, 2015, patient L.D.'s graft was patent (open or exposed), however, Respondent placed a central venous catheter in patient L.D.;

(b) For patient L.D.: On or about February 4, 2015, Respondent performed a thrombectomy and revision of a right arm graft on patient L.D., without describing the revision in patient L.D.'s medical records;

(c) For Patient B: On or about January 17, 2013, after patient B had suffered postoperative bleeding, Respondent attempted thrombosis in the immediate post-operative period, but inadequately documented Patient B's medical records, including

failures to document the patient's examination; and/or a discussion of alternatives with patient; and/or a discussion of risks and benefits of various action with patient; and/or the patient's agreement.

(d) For Patient B: On or about January 16, 2013, Respondent failed to perform and/or order adequate intraoperative imaging after the initial thrombectomy and patch angioplasty;

(e) For patient C.L.: On or about February 14, 2014, Respondent created an inadequate operative report for the catheter replacement, by his failure(s) to document whether the patient's catheter was tunneled to a different exit site; and/or; to adequately document how the patient was managed; and/or to document whether the patient's catheter was tunneled through an area of infection;

(f) For patient C.L.: Respondent failed to adequately document the office notes in the patient's medical records, in that he failed to document: examination; and/or failed to identify whether the fistula was thrombosed or non-matured; and/or failed to document the date of the revision surgery; and/or the January 19, 2014 consultation;

(g) For patient C.L.: On or about February 10, 2014, Respondent failed to examine and assess the arteriovenous access; and

(h) For patient P.S.A.: On or about February 29, 2012, Respondent attempted a primary repair of patient P.S.A.'s "destroyed" cecum, instead of performing a ileocecectomy.

(i) For patient W.P.: Respondent documented only pain, and failed to document the following indications for surgery, which would include but not be limited to a description of lower extremity ischemia, pallor, coolness, paresthesia (numbness), paresis, and/or ischemic chest pain.

(j) For Patient A: On or about January 25, 2013, Respondent used bioprosthesis without appropriately reporting its use in the patient medical records.

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(k) For Patient C: On or about February 27, 2015, Respondent conducted a laparoscopic cholecystectomy in which he retracted the gallbladder superiorly and caused a common bile duct injury which resulted in subsequent hospitalizations and additional surgical procedures to address the situation.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

19. Respondent has further subjected his Physician's and Surgeon's Certificate No. G42802 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain accurate and adequate medical records in his care and treatment of patients L.D., W.P., C.L., A. and B., as more particularly alleged hereinafter:

20. Paragraphs 7 through 18, above, are incorporated by reference and realleged, as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

21. To determine the degree of discipline, if any, to be imposed on Respondent's Physician's and Surgeon's Certificate No. G42802, Complainant alleges the following factors in aggravation:

(a) On or about May 18, 2005, the then-Executive Director of the Medical Board filed Accusation 18-2002-134149 against Respondent's Physician's and Surgeon's Certificate No. G42802, alleging that Respondent committed eleven acts of gross negligence, repeated negligence and incompetence in his care and treatment of seven patients (patients M.G., J.G., C.L., W.M., B.B., T.G., and J.J.) and committed three acts of inadequate or inaccurate record keeping in his care and treatment of two patients (patients J.W. and T.G.).

(b) Effective on or about May 25, 2007, the Medical Board of California adopted a Stipulated Settlement and Disciplinary Order, which provided, in pertinent part, that Respondent did not contest that at an administrative hearing Complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation 18-2002-134149, and agreed that the charges and allegations shall be deemed true and correct for purposes of any proceeding involving a petition for modification or early termination, and any other licensing proceeding

involving Respondent and the State of California. The probationary terms placed Respondent on probation for five years, and required him to successfully complete a clinical training course (PACE), a medical record keeping course, additional hours of education, to work with a practice monitor, and to comply with other terms of probation.

(c) Respondent requested and received a stay of that Decision and Order in Case No. 18-2002-134149. Execution of the Order was stayed from May 25, 2007, until June 4, 2007.

(d) On or about January 11, 2010, Respondent filed a Petition for Early Termination of Probation. His Petition was granted, terminating Respondent's five-year probation effective April 1, 2011.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G42802, issued to Respondent Harry Lifschutz, M.D.;

2. Revoking, suspending or denying approval of Respondent Harry Lifschutz, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Harry Lifschutz, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 4, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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